Child Survival
CONNECTIONS
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Photo by Emmanuel d'Harcourt

A mother in the IRC/Rwanda Child Survival project catchment area responds to Knowledge, Practices, and Coverage (KPC) questions during the baseline survey.

The KPC as a Partnership Tool

The International Rescue Committee (IRC) and Rwanda's Kibungo Health Region conducted a Knowledge, Practices, and Coverage (KPC) survey in September of 2000 as part of the Kibungo Child Survival Project. In this article, we discuss the way in which the KPC was used to strengthen the relationship between IRC and the Ministry of Health (MOH) and to build a stronger foundation for a child survival project.

The Setting

The Kibungo program is the first child survival project for both IRC and the Ministry of Health. The program began in October 1999, with a focus on reproductive health and nutrition. Before the KPC survey the project had achieved some success, but it had also encountered difficulties.

On the positive side, the project was building on six years of partnership between IRC and local health officials. The project's community-oriented objectives corresponded to the Ministry of Health's new focus on community health. The information systems for health animators and traditional birth attendants, designed by IRC and district health officials, were beginning to show promising results and had received the official endorsement of the regional medical officer. Thus, the building blocks of partnership were all there: trust, common objectives, and agreement on strategies.

Yet there were also significant problems. Although local health officials were consulted during the writing of the proposal, and although the project corresponded to MOH objectives, the officials had done little of the actual work on the proposal and they felt no ownership. They were also doing little of the actual work of implementing the project; instead, they passively approved IRC initiatives.

Why was there so little ownership at the beginning of the program, even though there had been such efforts at consultation?

One answer is that although there had been consultation, the MOH was not brought in as a full partner. The MOH staff did not see the request for application and did not participate in the actual drafting and writing of the proposal.

Another reason is that MOH staff had not been presented with the data that justified the child survival project's existence. After they saw the information–from the KPC and from the project's information systems–they became much more committed partners.

For both of these reasons, initial partnership would have been improved if key MOH staff had been involved in the initial data-gathering. Seeing initial data is often eye-opening, even if one has been working in the area, and gathering data oneself is often much more convincing than being served the processed information by an external consultant.

How the KPC was set up

Because neither IRC nor local health officials had KPC experience, a consultant was hired for the survey. Dr. Ndeye Fatou Ndiaye–who was recommended, through CSTS by PLAN International–was a veteran of five KPC surveys. The Kibungo regional administrator and the program manager held several meetings to prepare for her arrival. Normally, finding the time to hold such meetings would not have been easy. But the arrival of a consultant, and the need to make the most of the little time she had in Rwanda, were enough

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What helped

Factors that helped the IRC and the MOH to work together included:

- *Having a consultant with the appropriate attitude and skills.* From the outset, Dr. Ndiaye was interested in having the survey be a collaboration, which was in line with IRC's approach in all its programs, including health. Furthermore, Dr. Ndiaye had the facilitation skills to go along with that attitude: she knew how to get everyone to participate, without paralyzing the process.
- *Having a consultant familiar with local conditions.* Because she had worked in several African countries, Dr. Ndiaye was very quick to understand conditions in rural Rwanda. As a health official herself (she works for the nutrition division of the Senegalese Ministry of Health), she knew how to work with the Rwandan MOH staff and was more easily accepted by them.
- *Having a base of motivated district-level officials.* The partnership would not have worked if there had not been enough district officials with the motivation to learn and the skills and energy to carry out the survey.
- *Having commitment from the top.* Having the visible endorsement of the regional medical officer helped to motivate middle-level officials who did most of the work.
- *Most important of all, common objectives.* The success of the MOH/IRC partnership before, during, and after the KPC survey was based on the fact that both organizations felt community-level interventions were needed to improve the health of the population, and that such interventions needed to be based on better community-level information (such as that provided by the KPC). Without this common understanding, no partnership would have been possible.

to make holding meetings a priority for the program manager and MOH leaders.

When the consultant arrived, she, the manager, and the administrator prepared a presentation to be given the next day to the regional medical officer and district officials. Importantly, it was the administrator–and not the consultant or the program manager–who made the presentation. As IRC has repeatedly found in Kibungo, having an "inside presenter" dramatically increases buy-in from partners. This makes sense: if one wanted to make a pitch for funding from Bill Gates, it would be preferable to have his trusted assistant, rather than an outside consultant, give the presentation. The consultant and the program manager both felt strongly about this and were able to convince an initially reluctant administrator to make the presentation. The fact that the presentation was very well received sent the message early on that the MOH would be fully involved.

Timeline

- August 28: Core team training
- August 30: Supervisor training
- August 31: Surveyor training
- September 2: Pretest
- September 5-7: Survey
- September 8-18: Data entry and analysis
- September 19: Results presented to regional medical officer.

During the meeting, regional and district officials named a KPC "core team," with representatives from each institution, to lead the survey. At the regional medical officer's request, two representatives from the central MOH in Kigali were also named to the team. The core team was a natural idea, because ministries and other public bodies in Rwanda frequently appoint similar committees to lead a particular project. Since the survey was presented as an MOH effort from the start, it made sense for it to be led by a similar committee. The concept was popular for other reasons, not the least of which is that officials supposed it would be financially advantageous.

How the KPC was carried out

From the outset, the core team took charge. During initial training, the KPC committee was

very active, making many changes to the draft questionnaire. There was an excellent relationship with the consultant, who was able to share her experience and her expertise without stifling participation. There was a genuine sense of excitement: long hours but lots of discussion and lots of laughter. Core team members showed considerable initiative. For example, when the sampling clusters had to be redone because of changed population estimates, a district official–who had merely watched the first time–was able to do it on his own, teaching an audience of some 30 interviewers and supervisors as he did so.

Key benefits of KPC partnership

- Smoother logistics
- Better acceptance of results
- Better building of survey capacity, both for future KPCs and for other types of surveys
- Better partnership after the survey.

The core team did countless other tasks: identifying interviewers and supervisors (not an easy job in Rwanda, where because of the genocide, skilled workers are hard to find) training them, obtaining government approval, and last–but certainly not least–making most of the logistical arrangements for a 60-cluster survey. After the survey began, the core team provided a second level of supervision, visiting every field team every day, checking each and every questionnaire. Having local health officials involved at every step made the going smoother: it was easier to get population figures, easier to identify possible interviewers, easier to get permission from local political figures, and easier to find transport for interviewers.

The regional medical officer, Dr. Guido Rugumire, was present throughout the process: helping to revise the questionnaire and decide on key indicators, visiting the field teams, and participating in planning sessions at the end of each day. His presence was extremely important, because it gave a clear message to all government participants that the survey was an integral part of the Ministry of Health's work, not an outside project.

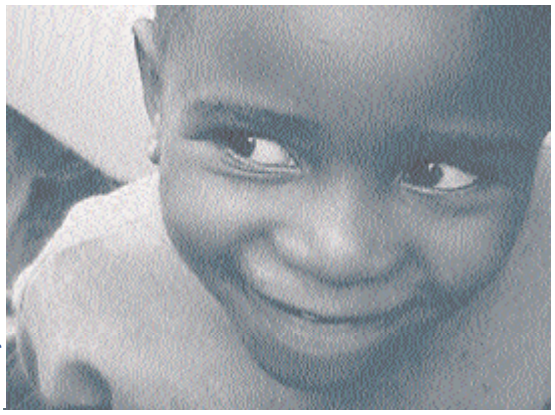

Photo by Emmanuel d'Harcourt

By working together, IRC and the Ministry of Health are building their capacities to serve children in the Kibungo Region.

How the results were analyzed and presented

Although having the partnership helped with logistics, the real payoff came when it was time to look at results. The regional medical administrator and several district officials obtained the initial numbers. The regional administrator and one of the district medical officers made the official presentation. Since most of the audience of regional and district officials knew the questions by heart, they were all the more curious about the results. Having drafted the questions, trained and supervised the interviewers, and pulled the numbers out of the computer themselves, everyone involved found it much easier to understand, to believe, and to accept the survey's findings. One of the district leaders summed it up best when, after the presentation (which showed very low figures for prenatal and growth monitoring), he said, "We have a lot of work to do."

The cost of partnership

Partnership is actually, among other things, a cost-cutting measure. Although some money is spent training or providing transport, working with health officials helped to increase efficiency, thereby decreasing costs.

What happened afterward

The success of the KPC survey–the Ministry of Health's involvement and the acceptance of the results–translated almost immediately into further benefits. The KPC core team became,

with a few changes, the Detailed Implementation Plan (DIP) Committee: a group of IRC and MOH staff who would work together to build the Detailed Implementation Plan. During the writing of the DIP, all the participants were intimately familiar with the KPC survey results–not from reading the report but from having done the survey and report themselves. As most people reading this document know all too well, writing a DIP takes an enormous amount of commitment, and we could not have done it without the energy from the KPC, and without the KPC "core team" structure to provide leadership and organize the work.

We hope there can be many other benefits. For example, it is likely that several other child survival programs will be starting in Rwanda in the upcoming year. The KPC experience and capacity acquired by the Rwandan Ministry of Health could be used by the programs. This could save on expensive foreign consultants, further build local capacity, and by example, help build the partnership between private voluntary organizations (PVOs) and the Ministry of Health to work on the new projects. ●

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What capacity was built during the KPC?

MOH:

- Capacity to plan the human, logistical, and financial resources needed to carry out a large household cluster survey
- Capacity to identify relevant indicators
- Capacity to use sampling methods to randomly choose clusters
- Capacity to train supervisors and interviewers
- Capacity to analyze the data using Epi Info (limited, needs improvement).

IRC:

- Capacity to plan the human, logistical, and financial resources needed to carry out a large household cluster survey
- Capacity to set up structures that will help promote partnership during the survey
- Capacity to design an easy-to-use, easy-to-enter questionnaire
- Capacity to analyze the data by means of Epi Info and CSAMPLE
- Capacity to write a report
- Capacity to understand that for the next survey, we'd better give ourselves a little more time.

Steps you can take to promote KPC partnership

- Hire a consultant with a partnership attitude and good facilitation skills.
- Put together a core team that represents the best of your local partners.
- In addition to the core team, identify one or two high-level health officials with good leadership qualities who will have the time to coordinate involvement by the MOH.
- Make sure top officials support you and show their support publicly.
- Don't spare your partners the details: every step they participate in (doing the random sampling, creating the Epi Info questionnaire, tabulating the results) adds interest and ownership.

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